This packet is an example of the order in which documents should be filed. These are not examples of how to fill out forms/documents.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

Is this a new case? Yes ☐ No ☑ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☑

More than 15 Companion Cases ☐

09/10/2008
Date:(MM/DD/YYYY)

SSN: 000-00-0000

ADJ12345
Case Number 1

☑ Specific Injury
☐ Cumulative Injury

03/19/2005
(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 420

Body Part 2: 100

Body Part 3:

Body Part 4:

Other Body Parts:

Please check unit to be filed on (check only one box)

☑ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ VOC ☐ INT ☐ RSU

Companion Cases

☐ Specific Injury

Case Number 2

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title STIPULATIONS WITH REQUEST FOR AWARD

Date of document following Document Separator Sheet

Document Date _____
MM/DD/YYYY

Author UNIFORM ASSIGNED NAME

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MM/DD/YYYY

DWC-CA form 10232.2

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
STIPULATIONS WITH REQUEST FOR AWARD

Case No. _____ Date of Injury _____ MM/DD/YYYY

SSN Numbers Only) _____

Venue Choice is based upon: (Completion of this section is required)

☐ Residence of employee (Labor Code section 5501.5(a)(1).)

☐ Location where injury occurred (Labor Code section 5501.5(a)(2).)

☐ Principal address of employee's attorney (Labor Code section 5501.5(a)(3).)

Select 3 Digit Office Code For Place/Venue of Hearing (From the Document Cover Sheet) _____

Applicant (Completion of this section is required)

Last Name _____ MI _____

First Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Employer #1 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words) _____

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code

Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer #2 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Employer #3 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Employer #4 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Labor Code Section 5313:

1. _____
Employees First Name

_____,
Employees Last Name

birth date _____, MM/DD/YYYY

while employed at _____, _____ State

as a(n) _____, _____ in
Occupation Group

☐ More than 4 Companion Cases

☐ Specific Injury

Case Number 1 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

☐ Specific Injury

Case Number 2 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

☐ Specific Injury

Case Number 3 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

☐ Specific Injury

Case Number 4 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

by the employers and their insurers listed above and who sustained injury(ies) arising out of and in the course of employment to

(Please list all body parts injured)

2. The injury (ies) caused temporary disability for the period _____ (MM/DD/YYYY) through _____ (MM/DD/YYYY) for which indemnity has been paid at $ _____ (Indemnity Paid) per week.

2(a).The injury(ies) caused additional temporary disability for the period _____ (MM/DD/YYYY) through _____ (MM/DD/YYYY) at the rate of $ _____ (Rate) in the amount of $ _____ (Indemnity Paid)

3. The injury(ies) caused permanent disability of _____ % for which indemnity has been paid at $ _____ (Indemnity Paid) per week beginning _____ (MM/DD/YYYY) in the sum of $ _____ ,less credit for such payments previously made ☐ And a life pension of $ _____ (Life Pension) per week thereafter.

Labor Code §4658(d) adjustment:

☐ Increase rate to $ _____ as of _____ (MM/DD/YYYY)

☐ Decrease rate to $ _____ as of _____ (MM/DD/YYYY)

☐ Not Applicable

An informal rating ☐ has / ☐ has Not (Select one) been previously issued Case No(s) _____ .

4.There ☐ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury(ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

6. Applicant's attorney requests a fee of $

☐ Fees to be commuted as follows:

7. Liens Against compensation are payable as follows:

8.Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

9.Other stipulations:

Dated _____ MM/DD/YYYY

_____ Applicant

Applicant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name _____

Last Name _____

Firm Number _____

Law Firm Number _____

_____

Address/PO Box (Please leave blank spaces between numbers, names or words

City _____ State _____ Zip Code _____

Dated _____ MM/DD/YYYY

_____ Applicant Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Non Attorney Representative ☐ Law Firm/Attorney

First Name

Last Name

Law Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words

City State Zip Code

Dated
MM/DD/YYYY

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words

City State Zip Code

Dated
MM/DD/YYYY

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words

City State Zip Code

Dated _____
MM/DD/YYYY

_____
Defense Attorney Signature

Interpreter Licence Number:

_____
Interpreter Name

_____
Interpreter License Number

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

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Author MEDICAL PROVIDER NAME

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JOHN A SMITH MD
JOHN A SMITH PT
Use only capital letters and no special characters e.g. / \ ' . " , : ; ( ) & !

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Received Date
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DWC-CA form 10232.2

[redacted]

[redacted]
Qualified Medical Evaluator
Diplomat, American Board of Physical Medicine & Rehabilitation
Diplomat, American Board of Electrodiagnostic Medicine (EMG)

[redacted] Evaluation

Patient	[redacted]
Evaluation Date	March 14, 2008
Date of Injury	March 19, 2005
Claim Number	[redacted]
WCAB Number	
Employer	

Interval History

Oral thrush

Oral thrush is still treated with Diflucan prescribed by [redacted]

Urticaria

Itching ostensibly due to Norco has resolved

Right upper extremity

Pain persists in the region of the right lateral epicondyle and extensor digitorum communis and radial tunnel

Left lower extremity

Pain has not changed and is provoked with prolonged standing.

Examination

Sitting

Sitting was again characterized by weight bearing on the right side and avoiding weight bearing on the left.

[redacted]

[redacted]
March 14, 2008
[redacted]
Page 2

Mouth

Tongue showed less fungal whiteness but a thrush-like appearance remained.

Elbow

Tenderness remained in the right epicondylar region.

Lumbar Sacral Region

Abnormal finding or pain that are absent are designated as 0, that are mild are designated 1, that are moderate are designated 2, that are severe are designated 3

Tenderness	Left	Right	Normal
Thoraco-lumbar junction	0	0	0
Lumbar sacral junction	1	1	0

Pelvis

Abnormal finding or pain that are absent are designated as 0, that are mild are designated 1, that are moderate are designated 2, that are severe are designated 3

Tenderness	Left	Right	Normal
Sacroiliac joint	1	1	0
Sacroiliac joint compression	1	1	0
Piriformis muscle	1	1	0
Posterior iliac crest	0	0	0
Sciatic notch	2	2	0
Anterior psoas tendon insertion	2	0	0

Straight Leg Raising

Straight leg raising aggravated pain. Pressure on the left posterior hamstrings above the knee and along the sciatica nerve aggravated significant pain. The same pain complaints were provoked with pressure on the buttocks and on the sciatic notch and even on the anterior pelvis in the region of the iliacus

Diagnostic Test

Magnetic resonance imaging of lumbar sacral spine on March 4, 2008 revealed L2-L3. L3-L4 2 to 3 millimeter far left lateral sub ligamentous protrusion with mild proximal left neural foraminal stenosis at both levels and 1 to 2 millimeter antero listhesis of L3 with respect to L4. At L4-L5 a 1-2 millimeter intervertebral disc bulge was noted. At L5-S1, a less than 2 millimeter intervertebral disc bulge was noted Left renal cyst was also found

[redacted] reported that on March 6, 2005 magnetic resonance imaging of the lumbar sacral spine revealed degenerative disc disease from L2 through S1, small posterolateral annular tears at L3-L4, L4-L5 and L5-S1, and facet arthropathy with mild neural foraminal stenosis at the left L5-S1 area with the left L5 nerve root displaced against the body of L5

In the cervical region the magnetic resonance imaging from March 4, 2008 showed a C3-C4, 1-2 millimeter left lateral intervertebral disc bud and osteophyte with mod left neural foraminal stenosis, a C5-C6 1-2 millimeter bugle and osteophytic ridge with moderate right mild left neural foraminal stenosis and borderline spinal canal narrowing, and C6-C7 1-2 millimeter lateral intervertebral disc bulge.

Diagnosis

L3, L4, L5, degenerative changes with annular degenerative changes primarily on the left side with left-sided sciatica with significant left-sided neural foraminal stenosis at the left L4 region, as noted on her most recent magnetic resonance imaging with significant sciatica noted on examination

Cervical degenerative disc disease with radiating pain to the proximal upper extremities

Left hemi hypalgesia, etiology unclear

Sleep disorder, aggravated by chronic pain

Depression and anxiety, aggravated by chronic pain

History of bladder incontinence, etiology unclear

History of adverse reactions to Baclofen, Cyclobenzaprine and Soma or Carisoprodol with the development of oral thrush

History of adverse reaction to Lyrica causing difficulty breathing

History of adverse reaction to Neurontin or Cymbalta, actual agent not clear, causing significantly increased pain in limbs and joints

History of adverse reaction to Norco or hydrocodone causing urticaria

History of adverse response to Sulfa causing difficulty breathing

Future Medical Treatment

Avoid

Baclofen, Flexeril and Soma as they aggravated thrush.

Lyrica due to adverse effects on her ability to breathe.

Neurontin as it provoked limb and abdominal pain.

Norco as it provoke urticaria.

Increase

Ultram to 300 milligrams ER in an attempt to reduce pain without increasing the amount of controlled substances

Restart

Cymbalta 20 milligrams once again to assess its efficacy on [redacted] sciatica versus adverse effects.

Start

TENS to reduce pain and muscle spasm and sciatica.

[redacted]

March 14. 2008

[redacted]

Continue

Percocet 5/325 to reduce sciatica even though it causes mild cognitive problems. This is preferable to other medications that have caused more adverse reactions

Consider

Other medication in an attempt to find one that does not cause adverse conditions but reduces sciatic pain. I will consider Mexilitine in subsequent evaluations to reduce nerve pain

Re-evaluate

In two weeks

Prolonged Evaluation

Added time was spent in educating [redacted] According to _Title 8 California Code of Regulations Sections 9792.20 - 9792.23, the Department of Industrial Relations has published a Medical Treatment Utilization Schedule to replace Chapter 6, Pain, Suffering, and the Restoration of Function of Occupational Medicine Practice Guidelines, Second Edition, of the American College of Occupational and Environmental Medicine (ACOEM Practice Guidelines) education is recommended The State of California Medical Treatment Utilization Schedule advises practitioners to develop and implement an effective strategy with skills to educate patients and recommends an education-based paradigm to start with inexpensive communication providing reassuring information to the patient The Schedule also recommends more in-depth education to exist within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. It advises that no treatment plan is complete without addressing issues of patient education as a means of facilitating self-management of symptoms and prevention

Declaration

I declare under penalty of perjury that I have not violated the provisions of California Labor Code 139 3 with regard to the evaluation of this patient or the preparation of this report

[redacted]

March 14. in the [redacted] California

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: ADJ

Document Type: MEDICAL DOCS

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Example:
JOHN A SMITH MD
JOHN A SMITH PT
Use only capital letters and no special characters e.g. / \ ' . " , : ; ( ) & !

Author: MEDICAL PROVIDER NAME

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Received Date
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[redacted]

[redacted]
Qualified Medical Evaluator
Diplomat, American Board of Physical Medicine & Rehabilitation
Diplomat, American Board of Electrodiagnostic Medicine (EMG)

Neuro-Diagnostic Evaluation

Patient	[redacted]
Evaluation Date	February 29, 2008
Date of Injury	March 19, 2005
Claim Number	[redacted]

Clinical Information

Evaluate for cause of pain in either leg.

Findings

Sural sensory studies recorded at the lateral ankles exhibited mildly slowed conduction velocities. Both peroneal sensory latencies recorded at both anterior ankles revealed normal conduction velocities

Evoked tibial motor compound action potentials recorded from the abductor hallucis muscles both ankles were normal. The late tibial H reflexes recorded from the calf muscles revealed a significantly prolonged latency in the right medial gastrocnemius muscles muscle The late tibial F waves recorded from the abductor hallucis muscle in either foot were normal. the peroneal motor studies of the regions between the popliteal fossas and fibular heads and the regions between the fibular heads and the ankles recorded from the extensor digitorum brevis muscles in both feet were within normal limits. The late peroneal F waves recorded from the extensor digitorum brevis muscles revealed a prolonged latency on the left.

Needle electromyography studies revealed normal findings bilaterally without evidence of radiculopathy or axonal degeneration. The conduction velocity studies, however, show findings that are compatible with mild polyneuropathy with possible mild polyradiculopathy.

Impression

Mild polyneuropathy with possible mild polyradiculopathy. Clinical corroboration is warranted.

[redacted]

POB 488
[redacted]

[redacted]

[redacted]

Diplomates Electrodiagnostic Med
[redacted]
Neurodiagnostic EMG & NCS

Patient: [redacted]
Skin temp: 32° C

Physician [redacted]
Test Date: 02/29/08

Motor Nerve Study

Peroneal Nerve

Rec Site EDB	Lat (ms)		Dur (ms)		Amp (mV)		Area (mVms)		Dist (mm)		C V (m/s)	
STIM SITE	L	R	L	R	L	R	L	R	L	R	L	R
Ankle	6 3	5 1	4 3	5 9	1 8	2 5	4 7	6 3	70	70		
Fib Head	13 8	12 3	6 5	5 9	1 9	2 3	5 8	7 2	380	330	50 1	45 5
Pop Fos	15 2	14 1	6 3	5 5	1 8	2 4	6 0	6 7	60	80	45 0	45 7

Tibial Nerve

Rec Site AH	Lat (ms)		Dur (ms)		Amp (mV)		Area (mVms)		Dist (mm)	
STIM SITE	L	R	L	R	L	R	L	R	L	R
Ankle	6 8	5 3	2 8	3 6	4 3	6 9	7 6	12 2	80	80

Sensory Nerve Study

Peroneal Nerve

Rec Site dors fi	Lat (ms)		Pk Lat (ms)		Amp (uV)		Dist (mm)		C V (m/s)	
STIM SITE	L	R	L	R	L	R	L	R	L	R
Lower leg	3 0	2 1	3 5	3 0	10 0	11 0	120	120	40 2	57 1

Sural Nerve

Rec Site Ankle	Lat (ms)		Pk Lat (ms)		Amp (uV)		Dist (mm)		C V (m/s)	
STIM SITE	L	R	L	R	L	R	L	R	L	R
mid calf	3 3	3 8	3 9	4 7	3 6	7 0	120	120	36 9	31 4

F-Wave Study

Peroneal Nerve
Rec Site EDB
Stim Site Ankle

	Latency ms	
	L	R
M wave	5 83	5 50
F wave	55 67	50 50
F-M	50 83	45 00

Tibial Nerve
Rec Site AH
Stim Site Ankle

	Latency ms	
	L	R
M wave	5 83	4 83
F wave	55 17	50 67
F-M	49 33	45 83

[redacted]

Patient: [redacted] 02/29/08 page 2

H Reflex Study

Tibial Nerve
Rec Site Soleus
Stim Site Pop Fos

	Latency ms L	R
M wave	6 67	6 00
H wave	34 50	38 33

Right Tibial Nerve
Rec Site Soleus
Stim Site Pop Fos

	Latency ms
M wave	6 50
H wave	40 50

EMG Study

Name	Ins Act	Fibs	PSW	Fascics	Polyph	MU Amp	MU Dur	Config	Pattern	Recruit
L Gastroc Med	norm	none	none	none	none	norm	norm	norm	norm	norm
L Gastroc Ln	norm	none	none	none	none	norm	norm	norm	norm	norm
L Peroneus Ln	norm	none	none	none	none	norm	norm	norm	norm	norm
L Tibialis An	norm	none	none	none	none	norm	norm	norm	norm	norm
L Ext Hal Ln	norm	none	none	none	none	norm	norm	norm	norm	norm
L Ext Dig Br	norm	none	none	none	none	norm	norm	norm	norm	norm
R Gastroc Med	norm	none	none	none	none	norm	norm	norm	norm	norm
R Gastroc Ln	norm	none	none	none	none	norm	norm	norm	norm	norm
R Peroneus Ln	norm	none	none	none	none	norm	norm	norm	norm	norm
R Tibialis An	norm	none	none	none	none	norm	norm	norm	norm	norm
R Ext Hal Ln	norm	none	none	none	none	norm	norm	norm	norm	norm
R Ext Dig Br	norm	none	none	none	none	norm	norm	norm	norm	norm

DOCUMENT SEPARATOR SHEET

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Proof of Service
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